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Rationing of Health Care in Britain: An Ethical Critique of Public Policy-making

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In Britain, as in the United States, rationing of health care is a fact of life and death. Some rationing is overt, such as the Stanford heart transplant program's decision not to accept very young or older patients.[1] Some is disguised, such as day-to-day decisions in hospitals about "do not resuscitate" orders[2] or the reported British reluctance to offer dialysis to older patients who might be a bit "crumbly."[3] Some rationing takes the form of absolute barriers to care, such as patient selection criteria. Some involves the refusal to fund care, with the practical result that care is beyond the reach of those who cannot pay. Whether all should have access to at least a decent minimum of health care, and whether rationing can be justified against the background assumption that they should, are complex moral issues, which we shall not tackle directly here.[4] Rather, our aim is to present two factors that are important for the implementation of a rationing policy to be justified, and to explore the extent to which these factors are realized in Britain. Our findings, that Britain falls short of these factors in some glaring ways, yet that rationing occurs, suggest that the rationing that takes place in the National Health Service is not justified at the present time.

First, a word about what we mean by rationing. We use the term very broadly, to include any situation in which distributive issues are taken into account to decide who gets care.[5] Thus, rationing occurs

when factors beyond the patient's interests or autonomy are figured into a treatment decision. Common examples of such factors include the patient's age (old or newborn),[6] social status, employment history, ability to pay, and likely life span, or quality of life. To discontinue care that merely prolongs the course of dying, and so will be of limited or no medical benefit, however, is not to ration in the sense with which we are concerned. To be sure, contrasts here are not sharp; quality of life can be so reduced, or life span so abbreviated that it is not in the patient's interests to continue care. The shift to a rationing decision occurs when considerations come into play about how resources could be used elsewhere—when the talk moves to how another patient might make better use of an intensive care unit bed.

Rationing decisions in this broad sense take place all the time. They are adopted as express social policy, such as limits on Medicaid eligibility in the United States, or the British decision to phase in heart and liver transplantation slowly.[7] They take place on the level of individual patient care, too, as when a busy British general practitioner devotes less than five minutes to a patient[8] or an American hospital ethics committee is asked to consider issues in the allocation of hospital resources to patient care.[9]

Justifying Rationing

Whether it occurs on the level of social policy or the level of delivery of care to individual patients, at least two, and perhaps three, factors are important for the rationing of health care to be justified. The importance of these factors is sufficient for our critique of Britain, and we do not make any further claims about whether they are individually necessary or jointly sufficient for rationing to be justified. The factors are, first, that the decision to ration was made with the participation of those whose interests are at stake (or their proxies, if necessary); second, that it was made with awareness that rationing was at issue; and, finally, that those with interests at stake had alternatives available, at least to some limited extent.

These factors are important for several reasons. Access to health care makes a great difference to the opportunities people have, to their ability to live without pain or discomfort, and to life itself.[10] Ill health can strike anyone, even those who take responsible care of their health. If ill health does strike, the financial consequences may be beyond the reach of even the deepest individual pocket or the most prudent individual efforts to buy insurance on the private market.[11]

The randomness of illness and the importance of health care to the

quality of life have been taken by some as arguments against rationing health care. In this chapter, we do not draw this inference, but do not thereby mean to suggest it is unjustified. Rather, we take the importance of health care, at minimum, as an argument for the opportunity to participate in a decision to ration. If the decision is to forego care because of its costs, those affected will be the individual patients; if the decision is a matter of social policy, they will be those who gain or lose access to care.

There has been recurring debate in Britain over the adequacy of British political institutions to respond to citizen concerns or to allow affected citizenry to become directly involved in administering programs such as the provision of health care. There are several ways in which such citizen participation might now take place. The traditional view of British political institutions is that Parliament fulfills two critical roles in translating popular preferences into public policy. First, by the doctrine of collective responsibility, the ministers of the government assume complete responsibility for the party's program and performance in office, thus permitting voters to judge, at the time of the general election, their satisfaction or dissatisfaction with the governing party's performance and, at the same time, the merits of the opposition party's proposals. Second, by the doctrine of individual responsibility, the individual minister is held accountable for the actions of his or her ministry's civil servants. According to this doctrine, a misapplication of rules or the abuse of authority by a local health authority is ultimately the responsibility of the minister in charge. Vehicles such as question time enable the members of Parliament to question the appropriate minister about local incidents as though the minister were cognizant of them (although of course he rarely is; nonetheless, he is constitutionally and politically responsible for them). The implication of the doctrine is that serious errors in administration lead to ministerial resignation.

Most commentators writing on the contemporary British constitution would question the extent to which the doctrines of collective and individual responsibility continue to reflect political reality, let alone effectively serve the purpose of legislative oversight. Governments often modify and equivocate on their programs, and few ministers ever resign. Indeed, the doctrine of individual ministerial responsibility may serve to cloak the actions of civil servants, rather than to reveal them to public scrutiny, because questions are directed to ministers and away from civil servants.

The National Health Service (NHS) has not been immune from efforts at reform to find alternative institutional means to achieve greater public scrutiny of and participation in policy-making. One such reform was the 1974 reorganization of the Service, a reorganiza-

tion that has undergone substantial subsequent modifications. The 1974 reform created fourteen regional authorities responsible for 90 Area Health Authorities, in turn, responsible for 199 District Health Authorities. These areal authorities were created largely to coincide with county boundaries drawn in a then recent local governmental reorganization. A stated goal of the NHS reorganization was to involve many more local authorities in the management of the NHS.

Along with this reorganization of the administrative structure, Community Health Councils (CHCs) were established for each health district. Their membership (of about 30 each) was drawn half from local authorities and half from local voluntary organizations and appointees of the regional Health Authorities. The objective of the CHCs was to represent the public to those who administer the NHS. It appears, however, that few members of the public even know of their existence. The CHCs are strictly advisory in their recommendations and are forbidden to organize nationally. Bates has argued that the CHCs, in spite of not being directly elected, have caused NHS officials to consider the interests of some patient groups that heretofore have been neglected. But Bates does point out that the CHCs cannot or have not been willing "to set priorities for the needs they uncovered and state which services could be reduced to enable the new services to be developed."[12] Most importantly, the efforts at oversight by either Parliament or by citizen bodies have been largely negligible in determining any sort of criteria for the allocation of scarce and expensive medical treatments. As discussed below, these allocative decisions have been the result of central budgetary decisions rather than policy deliberation.

A second factor of importance in the justification of rationing is public knowledge that a rationing decision is at stake. John Rawls has suggested that the requirement that moral principles be public is a "constraint of the concept of right."[13] He makes this suggestion because he believes moral principles are part of a public charter for social life. A community that acts on hidden moral principles lacks a shared moral life—and, not incidentally, is less likely to be one that justifiably claims the loyalty of its citizens.[14] What Rawls does not bring out is the equally important point that those who are left in the dark about the moral principles of their community are, in a sense, second-class citizens. They do not know by what principles their community functions. Not knowing, they will try to change principles with which they disagree. For example, citizens who do not know that their society rations health care, either as a matter of expressed or tacit policy, will not be moved to institute public moral debate on the matter. The practical value of their ability to participate is thereby diminished.

Moreover, those in the dark may easily be victimized by their ignorance. Whether intended or not, one effect of intentional secrecy is to make such victimization easier. No one has to face the pain of an identified victim, because the victims cannot identify themselves. It is much harder to tell a patient with end-stage renal disease that care would help him, but he cannot have it because society refuses to pay, than it is to appear to render a medical judgment that nothing can be done.[15] In rationing situations, it is comfortable to hedge. Hedging, in turn, makes the rationing easier, because no one has to openly face the true anguish of the choice. It also leaves the patient passive, since he does not know that there is any point in even looking for alternatives.

There are certainly a number of ways in which British health care policy can be communicated to the public. Ministerial statements, both in and out of Parliament, convey information. For example, there has been discussion lately of plans to increase the numbers of renal and heart transplants in Britain. Question time in Parliament can be used particularly as a way to air grievances about the impact of policy. The Department of Health and Social Services also issues occasional circulars setting forth policy. What we question below is whether information about policy has been fully articulated, and whether members of the British public have been made sufficiently aware about how policy is translated into practice to appreciate important implications of the translation for individuals' lives. For example, it is one thing to have a publicly-stated policy that the availability of dialysis is based on medical criteria, and another thing to implement financing policies that increase the likelihood that nonmedical factors such as chronological age will play an important role in allocation.

The third factor that makes rationing easier to justify is the availability of alternatives. When scarcity is absolute, it may not be possible to combine a just health care system with full access for everyone to medically feasible alternatives. For example, if the number of transplantable organs is biologically limited, and the supply falls short of needs, a public system of allocation may be the fairest method possible. To allow some private access to suitable organs would be to diminish the public supply.[16] The argument has been made that in any two-tier health care system, the presence of the upper tier threatens to undermine the quality of care available on the basic tier.[17] If there are situations in which the availability of alternatives does not threaten to undermine the quality of basic care, however, such availability makes rationing easier to defend. The individual who loses out on rationed care can seek other sources for care. If such other sources are legally but practically unavailable, most

likely because they are too expensive, rationing is correspondingly harder to justify because of the ultimate finality of its effects on lives. If the alternatives are legally prohibited, rationing is harder to justify still to those who have the resources and would choose to purchase care with them. It is perverse comfort to tell such people that they may spend their resources on other luxuries but not on health, especially when their decisions to purchase health would not diminish the resources available to others.

In Britain, for those who can pay for them, alternatives to the NHS are legally available. Private insurance plans fund dialysis, for example. Some organ transplants are funded privately.[18] And the ultimate step of going abroad is always a possibility for those with the means to do so. It should be emphasized, however, that these alternatives are beyond the financial reach of the majority of Britons. Moreover, if British patients are unaware that care is medically possible because allocative decisions are conveyed to them as medical judgments, even available alternatives may be left unexplored.

The NHS: Setting Rationing Policy

The motivating force in the development of the National Health Service was equity in the distribution and provision of medical services. Before the Second World War, there was widespread concern that the state-sponsored health insurance of the Edwardian Liberal governments had not gone far enough in providing health care for the less well off. Enforced migrations to rural areas during the bombings of the Second World War brought home to many Britons the existing sharp geographical differences in medical services and their costs. Some urban areas offered state-assisted medical care at little cost, while most rural areas were without. The war had generated, for many Britons, a strong commitment to equality in the sense that social services—notably health but also housing and education—ought to be made available to all, regardless of station or income.

The overriding concern with equality of access for all to medical services has been apparent throughout the nearly forty years of the Service's operation. Fairly regular investigations are conducted to see if, indeed, treatment has been equitably distributed by class and by region. Yet, there remain significant regional variations in the allocation of resources and persisting sharp differences in life expectations among social classes. For example, British unskilled manual laborers have a two-and-one-half-times greater chance of dying before reaching retirement age than British professionals. Data on self-reported morbidity, particularly chronic illnesses, parallel those on mortality.[19] These inequalities have troubled many proponents of the Health

Service, for whom the core value of the NHS is expressed in the personal experience of one of its most formidable defenders, the late R.M. Titmuss:

> Among all the other experiences I had, another which stands out is that of a young West Indian from Trinidad, aged 25, with cancer of the rectum. His appointment was the same as mine for radium treatments—10 o'clock every day. Sometimes he went into the Theratron Room first, sometimes I did. What determined waiting was quite simply the vagaries of London traffic—not race, religion, colour or class.[20]

The British commitment to equality has been expressed principally in terms of class and geography. Except in some early statements about the importance of the Service to the old and the young, the commitment to equality has not been expressed in terms of age. Class is indirectly related to age in so far as the elderly may be found in greater numbers among the poor. Beyond this indirect relation, however, the NHS has not emphasized age equity, and as we shall see, it appears that age rationing has taken place in practice within the NHS.

The wartime experiences of the population had included rationing of many resources on criteria independent of market allocation. The advocates of state-provided health care argued that medical treatment in postwar Britain should be severed from the marketplace, but delivered more effectively than under the old system. The many government reports that preceded the Act establishing the NHS went beyond treatment of illness by calling for promotion of the positive health of the nation.

The recognition that there would be increasingly hard choices to be made in allocating medical treatment was obscured in the political reality that allowed the National Health Service to come into existence in the postwar years. At that point, the potential—and expense—of medical care to improve life chances seemed likely to lie in better access and in the new wonder drugs, not in capital intensive, extremely expensive therapies. Medicine has, of course, been a rapidly changing field for decades, but what stands out is that many of the advances today are associated with complicated and expensive surgical techniques, in contrast to the 1940s when the emphasis was on new drugs, such as penicillin, that appeared to have vast capacities to cure disease.

What might be described as a second, more recent tradition in the assessment of medicine in Britain has been criticism of the role of technology. British medicine has been faulted for what is described as the undesirable import of American technological medical practices

with substantial investment in procedures to prolong life. The criticism is directed to transplants, both organic and mechanical, that seem to absorb significant resources and, in the view of some critics, to overestimate the prolongation of life while undervaluing the quality of life. The 1980 Reith lectures of Ian Kennedy are an example: "The other task doctors in hospitals are performing is that of calling upon more and more complex and expensive technology to respond to situations in which, when one looks at the general overall picture, there is usually little that can be done. To use the metaphor of the mechanic, the tyre can be patched, but even so, it is permanently weak." Kennedy's criticism of technological medicine is combined with a concern that it represents misplaced priorities:

> My second point is that, put baldly, certain services should not be offered until matters of greater priority are dealt with. There are perfectly respectable ethical theories that, in the context of harsh choices such a those we face now (and always as regards resources), allow for conduct that will benefit the larger worthy number even if this inevitably means others may suffer. One example was the decision in the second World War in North Africa that only those who on recovery would be able to fight again should receive scarce penicillin.[21]

This attitude that medicine should provide measured care instead of an all-out onslaught on serious ailments appears to be born out of newer doubts about technology's costs and beliefs in the limits of medical practice. This tradition may, as Aaron and Schwartz suggest,[22] remove some, but by no means all, of the pressure on physicians to engage in expensive procedures.

The great concern for equality and the sense of the limitations of medical treatment are the context in which the National Health Service has operated. Of equal significance to the formation of British health care policy has been the institutional development of the NHS. Until quite recently, the NHS placed the management of health services in the medical community. The compromise that developed between the Labour government of Aneurin Bevan and the British Medical Association during the establishment of the NHS was that doctors would be viewed as independent contractors who would retain autonomy in the performance of their services. In Britain, as in the United States, this is often described in terms of the inviolability of the doctor-patient relationship. By the same token, consultants (as we describe them, specialists) were given control over the administration of hospitals. In effect, a tripartite organization was set up composed of hospital services, community services (local health services), and family practitioner services. In the studies of the NHS, "the National Health Service was bound to be a 'doctor's service' much more than a 'patient's service.' "[23]

Of all the actions of the postwar Labour government, perhaps the most distinctive in organization was granting the medical profession the power to administer the National Health Service. The compromise was probably politically necessary to get the Service established. Nonetheless, the aim of the NHS was medical treatment for all, regardless of condition, and citizen as patient was not given a role in the direction of the NHS save in the form of Parliamentary review.

The 1974 reorganization of the Health Service, described above, was in part motivated by concern to increase participation at the local and lay levels. Local areal authorities were formed to improve coordination in the provision of services. The creation of the Community Health Councils was intended to involve members of the community in assessing the conditions under which medical treatment takes place. In practice, however, the Councils do not seem to have been major consumerist enterprises, but rather to have functioned as organs supporting NHS objectives.[24]

A far more potentially serious institutional modification of the NHS took place eight years later, with the introduction, in 1982, of a management council for the NHS. The Conservative government of the 1980s sought to introduce professional managers and tighter central control over the NHS. They also sought consideration of some forms of privatization in the provision of medical services. The 1982 management reform was seen by the Thatcher government as a crucial step towards cost effective decision-making in the NHS. Some of its apparent implications are discussed below.

Parliamentary review of the NHS has taken the form of the remarkable budgetary control correctly depicted by Aaron and Schwartz. The lid on medical expenditure—although not perhaps as apparent within Britain as it is to students of comparative health care costs—has meant that while the NHS has moved from about 3.2 percent of the GNP to about 5.7 percent in thirty-five years, it remains relatively inexpensive by the standards of other industrialized nations. The pattern in Britain for decades has been limited budgets given to the medical profession to determine, within those parameters, the allocation of resources for medical treatment. This allocation has been complicated more recently by the expense of innovations in medicine both at the diagnostic level and at the level of treatment. In the face of the changing nature of medical practice, the budgetary limitations set by Parliament pose increasing dilemmas for practitioners.

The key qualification of the hope of the NHS in the 1940s to sever the connection between market considerations and medical treatment was the role of the practitioner. In Britain, the need for medical treatment is determined in the first instance of patient care by the general practitioner (GP). The GP performs the central gatekeeping

role in the Service by first diagnosing the patient and then determining the type and extent of the treatment (if any) that the patient should receive. Most importantly, the GP determines if the patient should be sent to a consultant or to a hospital for further treatment.

Traditionally, British GPs have made decisions about patient care paternalistically, based on their assessment about what would be best for their patients. Patients are passive and deferential to authority. This passivity may be reinforced by British class structure and attitudes of resignation to illness. It is likely also reinforced by the gatekeeping system itself, under which the GP, not the patient, makes decisions about whether and which specialist to consult.[25] The legal standard in Britain for informed consent to treatment, for example, is what a reasonable physician would disclose; British courts have rejected as inappropriate for British medicine the standard of some American jurisdictions, that the physician must disclose what the reasonable patient would want to know.[26]

The concerns raised by this intersection of GP autonomy and paternalism begin with observation of treatment rates. A survey of disorders with known responsive procedures, found in the population at large in Britain, reveals that patients in Britain ailing from heart and kidney disease or hip problems appear to receive fewer transplants and hip replacements per million than patients in other advanced industrial nations.[27] Within Britain, moreover, there are wide regional and age disparities in rates of treatment.[28]

A central illustration of the dilemma confronting contemporary British medical practice is the introduction of dialysis for the treatment of end stage renal disease. By the early 1970s, British civil servants had become conscious that the new technologies in treatment of renal failure were fairly reliable, lifesaving, and expensive. Rapid advances in medical technology had generated what has been characterized as a "technological imperative." The new procedures were adopted, but incrementally, and it soon became apparent that the United Kingdom's rate of treatment was below that of other nations. The United Kingdom also relied more heavily on less expensive, nonhospital-based therapies such as home dialysis. According to Halper, the low treatment rate falls almost entirely upon those over the age of 45 or suffering complicating diseases.[29]

The willingness of British physicians to accept and work within such a limited program may have reflected a tradition of dealing with limited resources. It is important to emphasize that this tradition antedates the formation of the NHS. British hospitals were in short supply and often seriously outmoded by the 1930s. The war may have reinforced the notion of making do with what was available. Moreover, as Kennedy's Reith lectures seem to imply,[30] physicians

coming out of the Second World War may have continued to use the wartime criterion of triage: who can contribute productively to the struggle? Thus, in the 1950s, certain therapies in Britain were given to those who possessed a prior history of gainful employment and seemed likely to continue to work. Rehabilitation services and cataract surgery, for example, were, in the main, restricted to patients under 65.[31] This criterion of social usefulness, if understood in conventional terms, can adversely affect access of the elderly to treatment. It appears inferentially from the distribution of care such as dialysis that such an understanding may have occurred. This understanding is a particular irony since at the outset NHS policy statements had stressed the care of both the elderly and the young.

Halper[32] suggests some additional factors that may have contributed to the informal rationing system that appears to have developed among British physicians. Physicians' committees called to consult with the Ministry of Health about the introduction of dialysis were eager to get the program started and did not question its modest beginnings. The Ministry's interest in cost control coincided with the specialists' emphasis on establishing centers of excellence at major teaching hospitals. When responsibility for funding renal units was turned over to regional health authorities in 1971, it was done within the context of overall financial restrictions. Within this context, general practitioners, who in any event rarely encounter patients with end-stage renal disease, have not developed networks of experience in patient referrals, and may continue to work on outmoded medical assumptions about patient suitability for dialysis. Finally, perhaps because of discouragement and overwork, there are comparatively few nephrologists within the United Kingdom.

The inferential nature of the contention that British physicians employ nonmedical criteria in the allocation of dialysis must be emphasized. Despite the statistics about distribution of treatment, no criteria have been officially articulated by Parliament, the Department of Health and Social Services, or regional or local health authorities on how to allocate treatment for end-stage renal disease. Decisions not to treat those over 45, or those with complicating conditions, have not been made as formal public policy. The dialysis program was established on very limited grounds, and it appears that physicians allocated care within these limits on a more or less informal rationing basis. There is no written policy as to who should receive medical treatment in Britain. Indeed, British writing on health policy suggests an interesting paradox: a good deal of concern for the elderly, but the willingness to resort to an age criterion in times of hard choices.

This paradox may have emerged because the traditional purposes of the Health Service were equality between classes and geographical

region, not age cohorts. As we have suggested it also seems likely that institutional structure has played an important role in the apparent resort to age criteria. The preservation of the autonomy of the physician-patient relationship, in the light of limitations on resources, has allowed (or perhaps forced) physicians into establishing their own criteria for determining who is to receive treatment, and physicians appear to have been influenced by triage considerations.

The complexity and risk of the tight budgetary limitations and the failure to articulate criteria for the allocation of health care in a state system are apparent in increasing confrontation between some patient-oriented movements and the NHS. The British Kidney Patient Association (BKPA) claims that between 2000 and 3000 people die yearly from renal failure, and that some portion of these deaths are unnecessary because treatment facilities are too few in number and too unevenly distributed. To dramatize this claim, the BKPA has taken a patient who was refused treatment, and paid for his treatment privately. The Association plans to present the bill to the NHS for reimbursement.

The problem of being refused treatment grows in importance the older a patient becomes; so does the ethical dilemma and the potential legal dilemma faced by physicians. In the view of one commentator, Diana Brahams, the present policy of emphasizing the finite amount of money available and leaving decisions about how to allocate it to local authorities leaves the physician failing in his duty if he tells his patient he is untreatable, when he is indeed treatable but simply not going to be treated because of a lack of facilities. Brahams suggests that the National Health Service Act of 1977 imposes a duty on the Secretary of State for Social Services to provide treatment, and that the failure to treat a treatable patient may allow judicial review and an order for a mandamus to force the Secretary of State to carry out his duty to treat.[33]

Despite efforts by advocacy groups such as the BKPA, it is by no means apparent that we are about to see a significant rise in recourse to the law by British patients. Historically, British patients have not opted for legal action, nor indeed have they employed the NHS-established procedures for complaints. Explanations vary for the limited use of the complaints procedures. Some blame the formality of the procedures for the passivity of patients. It is apparent that while both patient and doctor can elect not to deal with each other and opt for other lists, British patients rarely change physicians except by geographical movement. In effect, the British physician-patient relationship is a remarkably quiescent one in which the patient has come to expect to deal with a single medical authority

over the course of much of his or her lifetime. This situation places immense responsibility on the physician, who knows in practice that the patient appears to have no real alternative source of medical advice, and limited prospects for a realistic exit from the medical system. Physician autonomy and Parliamentary cost concerns have interacted in Britain to produce a situation in which this responsibility is not fully exercised on the patient's behalf. Patients, however, may well remain unaware of the failure.

This historical pattern of decision-making for treatment policies in the NHS can surely be criticized. That criticism should not obscure, however, the institutional potential for devising national and explicit criteria for the treatment of patients requiring costly procedures. An illustration of this potential is the Thatcher government's change in NHS managerial strategy. The new strategy is controversial and, indeed, may have been imposed for what might be considered the wrong reasons, to hold steady or cut back health care costs. A national health care management board has been established with an aggressive, interventionist style of national management that seeks to establish efficient health care planning. Day and Klein argue, "The latest round of manpower targets shows that the Department's (Department of Health and Social Service's) long term concern with inputs is undiminished by its more recent interest in outputs."[34]

In large measure, however, the changes in NHS management reflect a new managerial approach in British government. Day and Klein argue that there is an effort for all governmental organizations to have a clear view of their objectives and the means to assess and measure performance in relation to these objectives. Organizations are to have well defined responsibility for making the best use of their resources, particularly money. The NHS, since 1948, has delivered services in response to local priorities of clinicians and health authorities as much as to the explicit directives of central political authorities.

Parliamentary accountability has not really existed for the NHS. The new management plan has potentially sweeping implications for the NHS of imposing a clear sense of national objective. Such a system could establish Parliamentary determination of what the NHS should be about. Presumably, such efforts as the issuance in 1983 of fourteen performance indicators to the fourteen regional authorities and the now 192 local authorities have given the opportunity for national comparisons. This emphasis on performance appraisal could generate pressure to establish differentiated criteria for the allocation of expensive therapies. The driving force for such explicit development of criteria would be to account for sharp regional differentiation in the allocation of therapies at present, and to permit Parliament to

come to terms with the de facto criteria for allocation that presently exist. Such a system of national objectives and strict accountability could lead to a sharp departure from the existing system of decentralized autonomy. By contrast, this potential for institutional change is not apparent in the decentralized American system.

The National Health Service was established with the goal of equalizing geographical and class access to medical care. It is ironic that the Service's institutional structure of physician control has discouraged public articulation of treatment goals. The result has been that as the Health Service developed, and costs of treatment increased, physicians have apparently tended to employ implicit rationing criteria. From the data about rates of treatment, it may be inferred that these criteria focus on likely social contribution, and age in particular.

Unfortunately, the use of these criteria was not developed as articulated public policy. To be sure, the increasing concerns of successive Parliament and governments to limit expenditures have been articulated public policy. The problem is not that people in Britain receive fewer hearts *per se*, or indeed, that the political authorities have determined that use of resources to increase such operations is unwise. Our concerns are whether or not there has been an articulation of the criteria actually used in the delivery of health care to British patients, either in the political arena, or on the level of individual patient care. Under the GP gatekeeping system, it is questionable whether knowledge of alternatives is presented to the patient or his designated guardians in a way that allows the opportunity for informed decisions about treatment. How general budgetary limits were to be translated into patient care has been left up to physicians, for the most part. The public, and individual patients, remained relatively unaware that rationing decisions were made because of budgetary limitations. These decisions were especially hard on the elderly. British policy articulated the need to cut health care costs, but did not articulate the bases on which hard choices were to be made.

Recent institutional reforms in the NHS appear to have created a structure within which such allocative criteria can be explicit, publicly responsible policy. Until they become so, however, the age rationing that has developed within the NHS must remain morally suspect. The lesson to be drawn from Britain to the United States is not simply, as Aaron and Schwartz say, that there are hard choices to be made. The other equally important lesson is that it matters institutionally how these choices are made and are communicated to those who must live or die with them.

Notes

1. Shumway now suggests it is medically possible to expand age parameters to below twelve and into, at least, the early 60s. Norman E. Shumway, "Cardiac Replacement in Perspective," *Heart Transplantation* 3:3–5 (1983). The Stanford program's oldest patient to date is in his early sixties.

2. See Steven S. Spencer, " 'Code' or 'No Code': A Nonlegal Opinion," New England Journal of Medicine 300:138–40 (1979).

3. H. Aaron and W. Schwartz, *The Painful Prescription*, Washington, D.C.: Brookings Institution, p. 35 (1984).

4. In a series of recent writings, for example, Norman Daniels argues that age rationing can be justified on prudential grounds. See *Just Health Care*, Cambridge: Cambridge University Press, 1985; "Justice Between Age Groups: Am I My Parents' Keeper?", *Milbank Memorial Fund Quarterly/Health and Society* 61:489 (1983).

5. This is not to equate rationing with any problem of scarcity, but to focus on considerations beyond the individual patient. David Mechanic, for example, characterizes rationing even more broadly then we do, as "no more than a means of apportioning, through some method of allowance, some limited good or service." "Cost Containment and the Quality of Medical Care: Rationing Strategies in an Era of Constrained Resources," *Milbank Memorial Fund Quarterly/Health and Society* 63:453–75, p. 457 (1985).

6. For a good example of the rationing dilemmas posed by the expense of neonatal care, see Tom L. Beauchamp and Laurence B. McCullough, *Medical Ethics: The Moral Responsibilities of Physicians*, Englewood Cliffs, N.J.: Prentice Hall, pp. 146–47 (1984).

7. See Miller, "Reflections on Organ Transplantation in the United Kingdom," *Law, Medicine & Health Care* 13:31–32 (1985). At least part of the delay is also to be attributed to difficulties in obtaining donor organs in Britain.

8. For a description of heavy patient loads of British general practitioners, see Ruth Levitt and Andrew Wall, *The Reorganized National Health Service*, London: Croom Helm, pp. 176–80 (1984).

9. E.g., Hospital Trustee Association of Pennsylvania, "Hospital Biomedical Ethics Committees," *Bioethics Reporter* 3:935 (1984).

10. Norman Daniels, for example, emphasizes opportunity. See Norman Daniels, "Health Care Needs and Distributive Justice," *Philosophy and Public Affairs* 10:146–79 (1981). The other factors may be important in their own right, however, and not simply because they enhance opportunity.

11. Because of their potentially cataclysmic costliness, health care needs are unlike food, housing, and other basic welfare needs. There is, thus, an argument for health insurance, but not for food insurance.

12. Erica M. Bates, *Health Systems and Public Scrutiny, Australia, Britain and the United States*, London: Croom Helm, p. 80 (1983).

13. John Rawls, *A Theory of Justice*, Cambridge: Harvard University Press, p. 133 (1971).

14. This position is not uncontroversial. Calabresi and Bobbitt argue to the contrary that in situations of tragic choice, it may be better for society to dissemble about the decisions being made than to admit openly the devaluation of human life. *Tragic Choices*. New York: W.W. Norton & Co. (1978).

15. In cases in which dialysis turns out to be of problematic benefit, decisions to stop treatment may be more common than is generally recognized. Patients and their families in such situations have a clearer idea of the impact of the therapy on the individual patients involved. It thus may be more reasonable to decide to discontinue treatment, than to refuse, at the outset, to give treatment a try. Neu and Kjellstrand, "Stopping Long-Term Dialysis: An Empirical Study of Withdrawal of Life- Supporting Treatment," *New England Journal of Medicine* 314:14–20 (1986).

16. For a good discussion of one state's efforts to handle this problem, see "Report of the Massachusetts Task Force on Organ Transplantation," *Law, Medicine and Health Care* 13:8–26 (1985).

17. E.g., Amy Gutman, "For and Against Equal Access to Health Care," in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care*, vol. 2, pp. 51–66 (1983).

18. Miller, "Reflections on Organ Transplantation in the United Kingdom," *Law, Medicine and Health Care* 13:31–32 (1985). Kidney transplants, for example, are performed at the Clementine Churchill Hospital near London, owned by American Medical International, with the kidneys being imported from the United States. Economist Intelligence Unit, *Private Health Care in the United Kingdom: A Review*. London: Economist Publications, p. 41 (1985).

19. "Inequalities in Health," *The Black Report*, Peter Townsend and Nick Davidson, eds. London: Penguin (1981).

20. Brian Abel-Smith and Kay Titmuss, eds., *Social Policy: An Introduction*, London: Allen and Unwin, pp. 150–51 (1974).

21. Ian Kennedy, "Unmasking Medicine," *The Listener*, p. 643 (Nov. 13, 1980).

22. H. Aaron and W. Schwartz, *The Painful Prescription*, Washington, D.C.: The Brookings Institution, (1984).

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24. Erica Bates, *Health Systems and Public Scrutiny, Australia, Britain and the United States*, London and Canberra: Croom Helm (1983).

25. Halper, "End-stage Renal Disease in the United Kingdom," *Milbank Memorial Fund Quarterly/Health and Society* 63:52–93, p. 69 (1985).

26. Schwartz and Grub, "Why Britain Can't Afford Informed Consent," *Hastings Center Report* 15:19–25 (1985).

27. H. Aaron and W. Schwartz, *The Painful Prescription*, Washington, D.C.: The Brookings Institution (1984).

28. Halper, "End-stage Renal Disease in the United Kingdom," *Milbank Memorial Fund Quarterly/Health and Society* 63:52–93, p. 55 (1985).

29. Ibid., p. 55.

30. Ian Kennedy, "Unmasking Medicine," *The Listener* (Nov. 13, 1980).

31. Halper, p. 61.

32. Ibid., pp. 57–59.

33. "End-stage Renal Failure: the Doctor's Duty and the Patient's Right," *The Lancet*, pp. 386–87 (Feb. 18, 1984).

34. Day and Klein, "Central Accountability and Local Decisionmaking: Towards a New NHS," *British Medical Journal*, p. 1676 (June 1, 1985).